Battersea Orthodontics Limited

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Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 12 May 2016 to ask the practice the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

We found that this practice was providing safe care in accordance with the relevant regulations.

Are services effective?

We found that this practice was providing effective care in accordance with the relevant regulations.

Are services caring?

We found that this practice was providing caring services in accordance with the relevant regulations.

Are services responsive?

We found that this practice was providing responsive care in accordance with the relevant regulations.

Are services well-led?

We found that this practice was providing well-led care in accordance with the relevant regulations.

Background

Battersea Orthodontics Limited is a dental practice located in the London Borough of Wandsworth. The premises are situated on the ground floor of a high-street location. There are three treatment rooms with a dedicated decontamination area behind a partition in one of the treatment rooms. There is also an X-ray room, two offices, reception area, and patient toilets.

The practice provides NHS and private services to adults and children. The practice specialises in the provision of orthodontic treatments.

There are twelve members of staff comprising the principal orthodontist, an associate orthodontist, an associate dentist who works as an orthodontic therapist, a hygienist, five dental nurses, a business manager and two receptionists. One of the dental nurses is employed as the clinical manager.

The practice opening hours are from 9.00am to 500pm on Monday, Wednesday and Friday, and from 9.00am to 6.00pm on Tuesday and Thursdays. The practice is also open for private appointments on the first Saturday each month between 10.00am and 2.00pm.

The principal orthodontist is the registered manager. A registered manager is a person who is registered with the CQC to manage the service. Like registered providers,

Summary of findings

they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the practice is run.

The inspection took place over one day and was carried out by a CQC inspector and a dental specialist advisor.

Ten people provided feedback about the service. Patients were positive about the care they received from the practice. They were complimentary about the friendly and caring attitude of the dental staff.

Our key findings were:

- Patients' needs were assessed and care was planned in line with current guidance such as from the National Institute for Health and Care Excellence (NICE).
- The practice had effective safeguarding processes in place and staff understood their responsibilities for safeguarding adults and children living in vulnerable circumstances.
- There were effective systems in place to reduce and minimise the risk and spread of infection. However, we identified some improvements that the practice should make to their infection control protocols.
- There were arrangements in place for managing medical emergencies. However, some of the equipment needed for responding to medical emergencies needing renewing or replacing at the time of the inspection.
- Staff recorded accidents. However, improvements were required as the practice needed to establish a system for recording and investigating incidents and significant events.
- Equipment, such as the air compressor, autoclave (steriliser), fire extinguishers, and X-ray equipment had all been checked for effectiveness and had been regularly serviced.
- Patients indicated that they felt they were listened to and that they received good care from a helpful and caring practice team.
- Staff maintained the necessary skills and competence to support the needs of patients.
- The practice had implemented clear procedures for managing comments, concerns or complaints.
- The provider had a clear vision for the practice and staff told us they were well supported by the management team.
- There were governance arrangements and audits to monitor and improve the quality and safety of the services. However, these could be improved through the use of a wider range of audits, for example of dental record keeping.

There were areas where the provider could make improvements and should:

- Review and establish a system for recording, investigating and reviewing incidents or significant events with a view to preventing further occurrences and ensuring that improvements are made as a result.
- Review availability of equipment to manage medical emergencies giving due regard to guidelines issued by the Resuscitation Council (UK), and the General Dental Council (GDC) standards for the dental team.
- Review the practice's infection control procedures and protocols giving due regard to guidelines issued by the Department of Health - Health Technical Memorandum 01-05: Decontamination in primary care dental practices and The Health and Social Care Act 2008: 'Code of Practice about the prevention and control of infections and related guidance.
- Review recruitment procedures to ensure accurate, complete and detailed records are maintained for all staff.
- Review the practice's audit protocols, such as those for reviewing the quality of dental care records, to help monitor and improve the quality of service. The practice should also check that, where appropriate, audits have documented learning points and the resulting improvements can be demonstrated.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We found that this practice was providing safe care in accordance with the relevant regulations.

The practice had systems in place to minimise the risks associated with providing dental services. The practice had policies and protocols, which staff were following, for the management of infection control, medical emergencies and dental radiography. There was a safeguarding lead and staff understood their responsibilities in terms of identifying and reporting any potential abuse.

We found the equipment used in the practice was well maintained and checked for effectiveness. The exception to this was the maintenance of the oxygen cylinder required for medical emergencies. Some additional items were also required for the medical emergencies kit.

We also noted that improvements needed to be made to the systems for identifying, investigating and learning from incidents relating to the safety of patients and staff members.

The clinical and business managers responded promptly to our feedback on these topics and sent us confirmation via email, after the inspection, that these issues were being addressed.

Are services effective?

We found this practice was providing effective care in accordance with the relevant regulations.

The practice specialised in orthodontic treatment. Patients received an assessment of their dental needs including recording and assessing their medical history. The practice monitored patients' oral health and gave appropriate health promotion advice. The practice kept detailed dental records of oral health assessments, treatment carried out and outcomes of treatment. Current clinical guidelines were considered in the delivery of orthodontic care and treatment. Staff explained treatment options to ensure that patients could make informed decisions about any treatment. The practice worked well with other providers and followed up on the outcomes of referrals made to other providers.

Staff engaged in continuous professional development (CPD) and were working towards meeting all of the training requirements of the General Dental Council (GDC). Staff had received appraisals within the past year to discuss their role and identify additional training needs.

Are services caring?

We found that this practice was providing caring services in accordance with the relevant regulations.

The practice provided clear, written information at the practice which supported people to make decisions about their care and treatment. The orthodontists demonstrated that they provided people with explanations about the risks and benefits of different treatments. These conversations were documented in patients' dental care records. This supported people to be involved in making their own choices and decisions about their dental care.

We received positive feedback from patients. Patients felt that the staff were kind and caring; they told us that they were treated with dignity and respect at all times. We found that dental care records were stored securely and patient confidentiality was well maintained.

Are services responsive to people's needs?

We found that this practice was providing responsive care in accordance with the relevant regulations.

Summary of findings

Patients had good access to appointments, including emergency appointments, which were available on the same day. The culture of the practice promoted equality of access for all. The practice was wheelchair accessible with treatment rooms situated on the ground floor.

There was a complaints policy in place. One complaint had been received within the past year. This had been recorded and appropriately investigated. Patient feedback, through the use of a monthly patient satisfaction survey, was used to monitor the quality of the service provided.

Are services well-led?

We found that this practice was providing well-led care in accordance with the relevant regulations.

The practice had clinical governance and risk management structures in place. These were well maintained and disseminated effectively to all members of staff. A system of audits was used to monitor and improve performance. There were some areas where risk management and audit processes could be improved. This included protocols in relation to investigation of incidents and the carrying out of dental record keeping audits.

Staff described an open and transparent culture where they were comfortable raising and discussing concerns with each other. They were confident in the abilities of the principal dentists to address any issues as they arose.

Battersea Orthodontics Limited

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the practice was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

We carried out an announced, comprehensive inspection on 12 May 2016. The inspection took place over one day and was carried out by a CQC inspector and a dental specialist advisor.

We reviewed information received from the provider prior to the inspection. During our inspection we reviewed policy documents and spoke with eight members of staff. We conducted a tour of the practice and looked at the storage arrangements for emergency medicines and equipment. One of the dental nurses demonstrated how they carried out decontamination procedures of dental instruments.

Ten people provided feedback about the service. Patients were positive about the care they received from the practice. They were complimentary about the friendly and caring attitude of the dental staff.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

These questions therefore formed the framework for the areas we looked at during the inspection.

Are services safe?

Our findings

Reporting, learning and improvement from incidents

Staff understood the process for accident and incident reporting including the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). There was an accidents reporting book; no accidents had occurred within the past year.

However, there was no policy or other system in place for reporting and learning from incidents. We discussed this with the principal dentist and practice managers. We noted two incidents that had occurred in the past year; the first related to a failure to replace equipment in a timely manner and the second was an incident that was reported to the police. The staff were able to describe the actions they took at the time to remedy the problems.

We discussed the investigation of incidents with a range of staff. They told us that they were committed to operating in an open and transparent manner. Patients would be told if they were affected by something that went wrong; they would offer an apology to patients, and inform them of any actions that were taken as a result. Improvements could, however, be made to ensure staff were aware of the Duty of Candour requirements. [Duty of Candour is a requirement under The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 on a registered person who must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity].

Reliable safety systems and processes (including safeguarding)

The business manager was the named practice lead for child and adult safeguarding. They were able to describe the types of behaviour a child might display that would alert them to possible signs of abuse or neglect. The practice had a well-designed safeguarding policy which referred to national guidance. This contained information about the local authority contacts for safeguarding concerns. There was evidence in the staff records that we checked which showed that staff had received training in safeguarding adults and children

The practice had carried out a range of risk assessments and implemented policies and protocols with a view to keeping staff and patients safe. For example, we asked staff about the prevention of sharps injuries. Staff were clear that the orthodontists were responsible for the disposal of wires and other sharps used in orthodontic treatment. There was a practice protocol in place for staff to follow in the event of a sharps injury.

Medical emergencies

The practice had arrangements in place to deal with medical emergencies. The practice had an automated external defibrillator (AED) and an oxygen cylinder, in line with the Resuscitation Council UK guidelines (An AED is a portable electronic device that analyses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm). The oxygen cylinder was being regularly checked by a member of staff to ensure that it remained effective. However, we found that the oxygen cylinder was past its use by date of March 2014 and five-year servicing date for March 2016. The business manager had identified this issue on the day before the inspection and a new cylinder had been ordered. They agreed that the system for undertaking checks needed to be made more robust to identify this risk.

We also found that not all of the equipment recommended by the Resuscitation Council UK was available at the time of the inspection. For example, not all sizes of airways equipment were available. There was also no self-inflating bag. The practice sent us evidence via email, after the inspection, that these items had been ordered.

The practice held emergency medicines in line with guidance issued by the British National Formulary for dealing with common medical emergencies in a dental practice. The emergency medicines were all in date and stored securely with emergency oxygen in a location known to staff.

Staff received annual training in using the emergency equipment. The staff we spoke with were all aware of the location of the emergency equipment.

Staff recruitment

The staff structure of the practice consists of the principal orthodontist, an associate orthodontist, an associate dentist (who currently works as an orthodontic therapist), a hygienist, five dental nurses, a business manager and two receptionists. One of the dental nurses is employed as the clinical manager.

Are services safe?

There was a recruitment policy in place which stated that all relevant checks would be carried out to confirm that any person being recruited was suitable for the role. This included the use of an application form, interview, review of employment history, evidence of relevant qualifications, the checking of references and a check of registration with the General Dental Council. We checked a random sample of the staff records. We found that the majority of the relevant documents had been obtained prior to employment.

However, we noted that for some staff there were no written references held on file. We discussed this with the clinical manager. They told us that they had obtained verbal references for these members of staff, but had not kept a record of these conversations. They noted that such a record would now be obtained when recruiting new members of staff.

It was practice policy to carry out a Disclosure and Barring Service (DBS) check for all members of staff prior to employment and periodically thereafter. We saw evidence that all members of staff had a DBS check. (The DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

Monitoring health & safety and responding to risks

There were arrangements in place to deal with foreseeable emergencies. We saw that there was a health and safety policy in place. The practice had been assessed for risk of fire and there were documents showing that fire extinguishers had been recently serviced.

There were arrangements in place to meet the Control of Substances Hazardous to Health 2002 (COSHH) regulations. There was a COSHH file where risks to patients, staff and visitors associated with hazardous substances were identified. Actions were described to minimise identified risks. COSHH products were securely stored. Staff were aware of the COSHH file and of the strategies in place to minimise the risks associated with these products.

There was a business continuity plan in place. There was an arrangement in place to direct patients to other local practices for emergency appointments in the event that the practice's own premises became unfit for use. Key contacts in the local area were kept up to date in the plan for reference purposes in the event that a maintenance problem occurred at the premises.

The practice had a system in place for receiving and responding to patient safety alerts, recalls and rapid response reports issued from the Medicines and Healthcare products Regulatory Agency (MHRA) and through the Central Alerting System (CAS), as well as from other relevant bodies, such as Public Health England (PHE). Relevant alerts were disseminated to all staff via email.

Infection control

There were effective systems in place to reduce the risk and spread of infection within the practice. The clinical manager and one of the dental nurses were the infection control leads. There was an infection control policy which included the decontamination of dental instruments, hand hygiene, use of protective equipment, and the segregation and disposal of clinical waste. The practice had carried out practice-wide infection control audits every three months and found high standards throughout the practice. We noted that the last audit had been completed in April 2016.

We observed that the premises appeared clean and tidy. Clear zoning demarked clean from dirty areas in all of the treatment rooms. Hand-washing facilities were available, including wall-mounted liquid soap, hand gels and paper towels in the treatment room, decontamination room and toilet. Hand-washing protocols were also displayed appropriately in various areas of the practice.

We asked one of the dental nurses to describe to us the end-to-end process of infection control procedures at the practice. The protocols described demonstrated that the practice had followed the guidance on decontamination and infection control issued by the Department of Health, namely 'Health Technical Memorandum 01-05 - Decontamination in primary care dental practices (HTM 01-05)'.

The dental nurse explained the decontamination of the general treatment room environment following the treatment of a patient. We saw that there were written guidelines for staff to follow for ensuring that the working surfaces, dental unit and dental chair were decontaminated. This included the treatment of the dental water lines.

Are services safe?

We checked the contents of the drawers in the treatment rooms. These were well stocked, clean, ordered and free from clutter. All of the instruments were pouched. It was obvious which items were for single use and these items were clearly new. The treatment room had the appropriate personal protective equipment, such as gloves and aprons, available for staff and patient use.

The dental water lines were maintained to prevent the growth and spread of Legionella bacteria (Legionella is a term for particular bacteria which can contaminate water systems in buildings). The practice manager described the method they used which was in line with current HTM 01-05 guidelines. A Legionella risk assessment had been carried out by an external contractor in 2014. The practice was following recommendations to reduce the risk of Legionella, for example, through the regular testing of the water temperatures. A record had been kept of the outcome of these checks on a monthly basis.

The practice used a decontamination room for instrument processing. In accordance with HTM 01-05 guidance, an instrument transportation system had been implemented to ensure the safe movement of instruments between treatment rooms and the decontamination room which ensured the risk of infection spread was minimised. The process of cleaning, inspection, sterilisation, packaging and storage of instruments followed a well-defined system of zoning from dirty through to clean.

We observed one of the dental nurses working in the decontamination room. Instruments were manually cleaned and rinsed prior to being place in an autoclave (steriliser). We noted that the dental nurse wore some protective equipment, such as gloves, during the cleaning process, but did not wear an apron. We also observed that the manual cleaning did not take place under water, as recommended in HTM 01-05. Items were also not inspected under an illuminated magnifier to check for any remaining debris after cleaning.

When instruments had been sterilized, they were pouched and stored appropriately, until required. All of the pouches we checked had a date of sterilisation and an expiry date.

We saw that there were systems in place to ensure that the autoclave was working effectively. These included, for example, the automatic control test and steam penetration test. It was observed that the data sheets used to record the essential daily validation checks of the sterilisation cycles were complete and up to date.

The segregation and storage of dental waste was in line with current guidelines laid down by the Department of Health. We observed that sharps containers, clinical waste bags and municipal waste were properly maintained. The practice used a contractor to remove dental waste from the practice. Waste was stored in a separate, locked location within the practice prior to collection by the contractor. Waste consignment notices were available for inspection.

Environmental cleaning was carried out using cleaning equipment in accordance with the national colour coding scheme. There were cleaning schedules in place for cleaning the premises and cleaning records were maintained suitably. However, equipment that was used for cleaning the premises was not stored suitably in line with current guidelines.

Staff training records showed that the majority of staff regularly attended training courses in infection control. We found one example where this training had been infrequently renewed. The business manager sent us evidence after the inspection that staff had subsequently completed relevant training.

Clinical staff were required to produce evidence to show that they had been effectively vaccinated against Hepatitis B to prevent the spread of infection between staff and patients. (People who are likely to come into contact with blood products, or are at increased risk of needle-stick injuries should receive these vaccinations to minimise risks of blood borne infections.)

Equipment and medicines

We found that the majority of the equipment used at the practice was regularly serviced and well maintained. For example, we saw documents showing that the air compressor, fire equipment and X-ray equipment had all been inspected and serviced. Portable appliance testing (PAT) had been completed in accordance with good practice guidance in June 2015. PAT is the name of a process during which electrical appliances are routinely checked for safety.

The expiry dates of medicines, oxygen and equipment were monitored using weekly and monthly check sheets which

enabled the staff to replace out-of-date drugs and equipment promptly. However, this system had not been used effectively to identify the need to replace the oxygen cylinder in a timely manner. A new oxygen cylinder had been ordered at the time of the inspection, but the existing cylinder was out of date in terms of servicing the cylinder and pressure testing of the oxygen supply.

Radiography (X-rays)

There was a well-maintained radiation protection file in line with the Ionising Radiation Regulations (IRR) 1999 and Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER).This file contained the names of the Radiation Protection Advisor and the Radiation Protection Supervisor as well as the necessary documentation pertaining to the maintenance of the X-ray equipment. Included in the file were the critical examination packs for the X-ray set along with the three-yearly maintenance logs and a copy of the local rules. Audits on X-ray quality were undertaken at regular intervals. There was evidence in the staff records that they had completed radiography and radiation protection training.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The clinical staff we spoke with demonstrated that they carried out consultations, assessments and treatments in line with recognised general professional guidelines. They described to us how they carried out their assessment and treatment of patients. The assessment began with the patient completing a medical history questionnaire covering any health conditions, medicines being taken and any allergies suffered. We saw evidence that the medical history was updated at subsequent visits. This was followed by an examination of the patients jaw and tooth relationships and the factors that affected these relationships. X-rays were taken appropriately, in line with recognised guidance, to inform the orthodontist's assessment of their patients' needs.

Clinical assessment of children involved using the Index of Treatment Need (IOTN). The IOTN is used to assess the need and eligibility of children less than 18 years of age for NHS orthodontic treatment on dental health grounds. Following the clinical assessment the diagnosis was then discussed with the patient, their parents, guardians or carers and treatment options explained in detail.

We found from our discussions with clinical staff that dental care records, including details of assessments and treatment plans, were kept and reviewed appropriately in line with the National Institute for Health and Care Excellence (NICE) and national orthodontic guidelines (for example, from the British Orthodontic Society).The dental care record was updated with the proposed treatment after discussing options with the patient. A treatment plan was then given to each patient and this included the cost involved if private orthodontic treatment had been proposed. Patients were monitored through follow-up appointments.

Health promotion & prevention

The practice staff could demonstrate that they were aware of the Department of Health publication 'Delivering better oral health: and evidence based toolkit for prevention' and were working in line with this guidance. ('Delivering better oral health' is an evidence based toolkit used by dental teams for the prevention of dental disease in a primary and secondary care setting).

The practice staff told us that they considered that oral hygiene was an important factor in facilitating good orthodontic treatment. The orthodontists, orthodontic therapist and hygienist provided oral health advice. This included dietary advice and general oral hygiene instruction such as tooth brushing techniques or recommended tooth care products specifically designed for orthodontic patients. Smoking and alcohol advice was also given, where relevant.

There were a range of information leaflets available in the treatment rooms and waiting areas which contained information about effective dental hygiene during orthodontic treatment. Staff told us they also used 3-D modelling of patients' teeth, online resources, and information leaflets as a way of facilitating learning around oral hygiene with their patients. Oral health products were also available for sale at the reception desk.

Staffing

Staff told us they received appropriate professional development and training. We checked the records for seven members of staff and saw that this was the case. The training covered all of the mandatory requirements for registration issued by the General Dental Council. This included responding to emergencies, infection control, and radiography and radiation protection training.

There was an induction programme for new staff to follow to ensure that they understood the protocols and systems in place at the practice.

Staff told us they had been engaged in appraisal and supervision processes which reviewed their performance and identified their training and development needs. We reviewed some of the notes kept from these meetings and saw that each member of staff had the opportunity to put a development plan in place. We noted that some dental nurses had been supported by the practice to train for additional qualifications in oral health, the taking of X-rays and orthodontic nursing skills with a view to training to become orthodontic therapists.

Working with other services

The practice had suitable arrangements in place for working with other health professionals to ensure quality of care for their patients.

The principal orthodontist explained how they worked with other services, when required. The orthodontists were able

Are services effective?

(for example, treatment is effective)

to refer patients to a range of specialists in primary and secondary care if the treatment required was not provided by the practice. For example, the practice made referrals to other specialists for more complex cases where jaw alignment discrepancies warranted a further review. There were also systems in place for referring patients to hospital consultants using a fast track process for patients with a suspected case of cancer.

The principal orthodontist also told us that they worked with dentists in the local area to improve identification of appropriate cases for referral for NHS treatment at the practice. For example, they invited dentists to attend a yearly event where the Index of Treatment Need (IOTN) criteria were reviewed in order to support dentists in their identification of suitable patients. The IOTN is used to assess the need and eligibility of children less than 18 years of age for NHS orthodontic treatment on dental health grounds.

We reviewed the systems for referring patients to specialist consultants in secondary care. A referral letter was prepared and sent to the hospital with full details of the dentist's findings and a copy was stored on the practices' records system. A copy of the referral letter was available to patients, on request. When the patient had received their treatment they were discharged back to the practice. Their treatment was then monitored after being referred back to the practice to ensure patients had received a satisfactory outcome and all necessary post-procedure care.

Consent to care and treatment

The practice ensured valid consent was obtained for all care and treatment. We spoke to one of the orthodontists about their understanding of consent. They explained that individual treatment options, risks, benefits and costs were discussed with each patient and then documented in a written treatment plan. They stressed the importance of communication skills when explaining care and treatment to patients to help ensure they had an understanding of their treatment options. Patients were asked to sign formal, written consent forms and copies of these were held with the patient's dental care record.

All of the staff members were aware of the Mental Capacity Act 2005. (The Mental Capacity Act 2005 (MCA) provides a legal framework for health and care professionals to act and make decisions on behalf of adults who lack the capacity to make particular decisions for themselves). The orthodontist was able to describe scenarios for how they would manage a patient who lacked the capacity to consent to dental treatment. They noted that they would involve the patient's family, along with social workers and other professionals involved in the care of the patient, to ensure that the best interests of the patient were met.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

The feedback we received from patients was positive and referred to the staff's caring and helpful attitude. Patients indicated that they felt comfortable and relaxed with the clinical staff and that they were made to feel at ease during consultations and treatments.

Staff were aware of the importance of protecting patients' privacy and dignity. For example, the treatment room doors were closed at all times when patients were having treatment.

Staff understood the importance of data protection and confidentiality and had received training in information governance. They were careful not to discuss issues concerning individual patients in the reception areas.

Patients' dental care records were stored in both paper and electronic formats. Records stored on the computer were password protected and regularly backed up. Paper records were stored in locked filing cabinets and were not left unattended in the reception area.

Involvement in decisions about care and treatment

The practice displayed information in the reception area which gave details of the NHS and private dental charges or fees. Information about the practice and its range of services was also available in an information leaflet in the reception area and on the practice's website.

We spoke with a range of clinical staff on the day of our inspection. They told us they worked towards providing clear explanations about treatment and prevention strategies. They used a range of strategies, including information leaflets and 3-D computer modelling of patients' jaws, to support their explanations of the possible treatment options.

The principal orthodontist told us that they worked hard to ensure that all patients were involved in the planning of their treatment and were supported throughout the treatment so that a good outcome could be achieved. For example, they continued to work with children who had ongoing problems with brace breakages. They supported them to understand how to care for the brace and how to keep their teeth healthy and clean during the treatment period.

We saw evidence in the dental care records that the staff recorded the information they had provided to patients about their treatment and the options open to them. The patient feedback we received confirmed that patients felt appropriately involved in the planning of their treatment and were satisfied with the descriptions given by staff.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice had a system in place to schedule enough time to assess and meet patients' dental needs. Some treatments had standardised timings, but the orthodontists and orthodontic therapist could determine the length of time needed for each appointment depending on their knowledge of each patient's needs. The feedback we received from patients indicated that they felt they had enough time with the dentist and were not rushed.

Reception staff told us that patients could book an appointment in good time to see the orthodontists or orthodontic therapist. The feedback we received from patients confirmed that they could get an appointment when they needed one, and that this included good access to emergency appointments on the day that they needed to be seen.

During our inspection we looked at examples of information available to people. We saw that the practice waiting area displayed a variety of information including opening hours and guides to different types of dental treatments. New patients were given a practice leaflet which included advice about appointments, opening hours and the types of services that were on offer. The practice had a website which reinforced this information.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its service. Staff told us they treated everybody equally and welcomed patients from a range of different backgrounds, cultures and religions. There was an equality and diversity policy which staff were following. The practice staff had access to a telephone interpreter service which could be used to support people to access the service.

The premises were wheelchair accessible, with access via a ramp at the entrance and level access to the treatment rooms, all of which were situated on the ground floor. There was also a disabled toilet. There was a hearing loop in the reception area.

Access to the service

The practice opening hours are from 9.00am to 500pm on Monday, Wednesday and Friday, and from 9.00am to 6.00pm on Tuesday and Thursdays. Private patients are also seen for appointments on the first Saturday of each month between 10.00am and 2.00pm.

We asked the clinical manager and reception staff about access to the service in an emergency or outside of normal opening hours. They told us the answer phone message and practice website gave details on how to access out of hours emergency treatment.

We were told that patients, who needed to be seen urgently, for example, because a wire on a brace had come loose, were seen on the same day that they alerted the practice to their concerns. The feedback we received via comments cards, and through speaking with patients on the day of the inspection, confirmed that patients had good access to the clinical staff in the event of needing emergency treatment.

Concerns & complaints

Information about how to make a complaint was displayed in a patient information leaflet and on a notice board in the waiting area. Patients were directed to ask the staff at the reception desk for further information about how to complain. We viewed a copy of the complaints policy and saw that it described how the practice handled formal and informal complaints from patients. There had been one complaint recorded in the past year. We saw that this had been investigated and responded to in line with the practice policy.

Patients were invited to give feedback through the NHS 'Friends and Family' test; we noted that between 6 to 10 responses were recorded each month. The information collected demonstrated that patients were satisfied with their care.

Are services well-led?

Our findings

Governance arrangements

The practice had governance arrangements and a clear management structure. There were relevant policies and procedures in place. Staff were aware of these and acted in line with them.

Records related to patient care and treatments were kept accurately and staff records were generally well maintained.

There were arrangements for identifying, recording and managing risks through the use of risk assessment processes. We identified a few areas, such as the protocols for recording and investigation of incidents, and contents of the emergency equipment, where improvements should be made. The principal orthodontist, who we spoke with about these issues, was responsive to our feedback and confirmed that they would act to remedy these concerns.

There were regular staff meetings to discuss key governance issues. We reviewed minutes from meetings held in the past year and noted that topics such as staff training, infection control, and information governance had been discussed.

Leadership, openness and transparency

The staff we spoke with described a transparent culture which encouraged candour, openness and honesty. The staff told us that they felt comfortable about raising concerns with the principal orthodontist and practice managers. They felt they were listened to and responded to when they did so.

We found staff to be hard working, caring towards the patients and committed to the work they did. Staff told us they enjoyed their work. They received regular appraisals which commented on their own performance and elicited their goals for the future.

Learning and improvement

The practice had a programme of clinical audit that was used as part of the process for learning and improvement. These included audits for infection control and X-ray quality. However, there had not been a formal audit of each clinician's dental care record keeping. The business manager sent us evidence after the inspection that such an audit had subsequently been carried out.

We also noted that the most recent infection control audit had not successfully identified concerns noted by our inspection team on the day of the inspection, such as the use of an illuminated magnifier after manually cleaning instruments.

Staff were supported to pursue development opportunities. For example, some of the dental nurses had completed additional training to allow them to carry out X-rays and had been encouraged to consider training to become orthodontic therapists. We saw evidence that staff were working towards completing the required number of CPD hours to maintain their professional development in line with requirements set by the General Dental Council (GDC).

Practice seeks and acts on feedback from its patients, the public and staff

The practice gathered feedback from patients through the use of the NHS 'Friends and Family' test. The majority of feedback had been positive. The practice had responded to feedback, for example, by working with staff on communication skills and offering staff customer service training.

The staff told us the principal orthodontist and practice managers were open to feedback regarding the quality of the care. The appraisal system and staff meetings also provided appropriate forums for staff to give their feedback.